DOCUMENT RESUME

ED 154 296 CG 012 566

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TITLE The Role of Cognitive Commitment Factors in Dieting and Psychotherapy.
PUB DATE 29 Mar 78
NOTE 11p.; Paper presented at the Annual Meeting of the American Educational Research Asscciation (March, 1978)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS *Behavicr Change; Dietetics; *Eating Habits; Individual Power; *Motivation; *Psychological Patterns; *Psychotherapy; Self Control; State of the Art Reviews
IDENTIFIERS *Obesity

ABSTRACT

Although motivation has long been regarded as essential for behavior, very little research has been done on its role in behavior change. This paper focuses on this issue by examining motivations for eating and dieting in obese and anorexic patients. Measuring the commitment to eating and the commitment to dieting, the study finds that motivations which influence behavior are often not immediately obvious. The dual issues of the motivations underlying a disorder and the motivations connected with seeking treatment, as examined in people with weight control problems, are relevant to most problems treated with psychotherapy. The paper concludes that without greater study of patient motivations, effective treatment of patients will remain a difficult problem. (Author/FC)

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The Role of Cognitive Commitment Factors in Dieting and Psychotherapy

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Presented at AERA, March 29, 1978

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The Role of Cognitive Commitment Factors

in Dieting and Psychotherapy

I will begin my presentation by discussing obesity and its treatment, partly because much of my research is on dieting, and partly because it is representative of the issues involving patients' motivations both towards their problem and its treatment. It is these issues I hope to bring to your attention today.

Recently, research on obesity and its treatment has focussed on the distinction between internal and external eating cues. Beginning with Schachter's work in the 1960's up to and including behavioral weight loss strategies, experimenters have emphasized physiological and environmental factors influencing eating, yet they have virtually ignored cognitive and motivational factors. The obese person is taught to restructure the environment to reduce food cues and fill up on non-caloric liquids and vegetables or exercise to reduce hunger. But what the obese person is saying to himself, and his reasons for dieting (or eating) are neither explored nor altered in therapy.

In the last few years, my colleague, Peter Herman, and I, along with our students, have been investigating the influence of a personality variable we call restraint on dieting, eating and other behaviours that differentiate the obese from normal weight individuals. Basically, restraint refers to a subject's degree of concern with dieting and eating and typical weight fluctuations. Among other things, we have found that it is this variable rather than body weight per se which underlies the so-called "obese behaviours" described by Schachter and his colleagues. For example, we find that restraint predicts distractibility, hyperemotionality, and "external" eating patterns (i.e., eating in response to anxiety or good taste) with restrained individuals acting like obese subjects in all cases. Furthermore, restraint predicts response to a high calorie preload such that restrained subjects actually overeat after a

calorie preload while unrestrained subjects sensibly reduce their subsequent intake in accordance with the size of the preload. This finding was the one we found most intriguing, especially in terms of its implications for dieting and weight loss. In exploring it further, we were able to establish that this disinhibition effect (as we called it or the "what the hell" effect as our students called it) is truly cognitive in nature. Restrained subjects ate more after a preload they thought to be high calorie than after one they thought to be low calorie, regardless of actual calorie content (unrestrained subjects ate slightly more after a preload they thought to be low calorie). Also, subjects' weight level per se did not predict the disinhibition effect at all. This led us to a short series of studies further delineating the extent of cognitive control over eating in restrained and unrestrained eaters, and the different uses of this cognitive control by the two groups. (It turns out that restrained eaters almost always act oppositely from unrestrained eaters unless they're being observed; then they act the same as unrestraineds, i.e., normal). From all this we concluded that success in dieting is very much subject to the influence of cognitive factors.

At this point, Roxy Silver, one of the students who had worked with us on the cognitive control of eating suggested a new direction. Roxy had also been working with Phil Brickman at Northwestern on the concept of commitment and its effects on one's life. Roxy made the connection between Brickman's work on commitment and our work on restraint and dieting and the four of us are now involved in pursuing this. I believe we are (at least among) the first to examine the relation between motivational factors associated with dieting and eating and actual dieting behavior and weight loss. We constructed two self-report inventories to measure what we call commitment to dieting and commitment to eating. Actually, these scales measure the quality of a person's

motivation to diet and motivation to eat (both of which seem to us to be crucial elements in determining behavior--and weight loss). We define high commitment as intrinsic motivation, that is, engaging in the activity for one's own reasons and rewards rather than in response to external pressures (extrinsic motivation). Thus, a person who is committed to dieting or eating as measured by our scale is one who diets or eats because it feels good, because he or she wants to diet, and who persists at it, and feels in control of the process. A person who is not committed to dieting or to eating, does so because he or she has to or feels forced to, sees the behavior as temporary, constantly checks his progress, and doesn't perform the behavior when it is inconvenient or difficult. The first thing we did was to give the new scales to samples of restrained and unrestrained subjects. To our surprise, we did not find differences in level of commitment to either activity between our groups (perhaps because all subjects were instructed to respond in terms of how they feel when performing the activity in question. Thus unrestrained subjects who don't diet often could still come out highly committed to dieting if they see themselves as intrinsically motivated on those occasions, however few, that they do diet). Next we looked at the eating behavior of these subjects. Our predictions are probably as obvious to you as they were to us--restrained subjects with a high commitment to dieting and low commitment to eating would eat the least, with subjects high in commitment to both dieting and eating coming next, and those low in commitment to dieting and highly committed to eating eating the most. For unrestrained subjects we didn't postulate as strong relationships, but assumed commitment to eating would be a better prediction of behavior since they are by definition subjects who do not diet very much. I won't bother going into any more detail on our predictions since they were mostly wrong. It turns out that we knew a lot less about the relation between motivation and

behavior than we thought we did. In fact, it was commitment to eating that predicted amount eaten for restrained subjects (there was a positive correlation) and commitment to dieting was essentially irrelevant, while for unrestrained subjects, commitment to dieting was better at predicting eating (there was a negative correlation) whereas commitment to eating was unrelated to behavior. Thus, the motivational variables we predicted would be most useful in predicting behavior in both groups (commitment to dieting for restrained and commitment to eating for unrestrained subjects) were totally unrelated to amount eaten ($r = .078$ for restrained, $r = -.071$ for unrestrained) whereas the motives expected to be peripheral at best turned out to be powerful predictions of behavior. What this all shows is that not only are the motivations we may consider the obvious important ones possibly unrelated to behavior, but motivations that might not appear to be immediately obvious can be influencing behavior without our knowledge.

This research is obviously not yet in a state suitable to allow me to pontificate on the importance of measuring motivation or commitment and changing it to facilitate behaviour change, but I do feel in a position to at least raise some issues and speculate on their implications.

To begin with, there are some questions I think should be asked (and ideally answered) about obesity. First of all, are there different kinds of motivations concerning eating? If so, what are the interrelationships among them? How many relevant motivations are there? How do we find out what they are? For example, is there a motivation to remain fat? Hilde Bruch and Mickey Stunkard certainly report case studies suggesting the existence of such a motive. How widespread is it and what is its contribution to obesity in the general population? Assuming there are various sorts of motivational factors influencing eating and obesity, how do these motivations develop? More

practically, how do we go about changing them? Must we change all of them or just one or two central ones? And the crucial question, does changing a person's motivations cause a change in his behavior? These questions are as yet unexplored. Our lack of success in treating obesity (and by success I mean large scale, long term weight loss and its maintenance) may result, at least in part, from our lack of knowledge about the questions I just outlined. Furthermore, these are not the only relevant questions. There has been a tendency to treat obesity as a unitary phenomenon (except in the relatively rare cases of glandular disorder). More recent research however has begun to focus on at least two types of obesity--adult onset and juvenile onset--and other investigators distinguish between hyperplastic (too many fat cells) and hypertrophic (fat cells are overgrown). There may well be other typologies we could identify to describe different obesity syndromes. It seems probable that there would be different patterns of motivation associated with these divergent types of obesity and these motivational differences would need to be dealt with accordingly.

These issues are not confined to the problem of obesity. Similar questions could be raised, for example, about an eating disorder at the other end of the spectrum, anorexia nervosa. (This is a disorder usually afflicting adolescent girls in which the patient stops eating and loses weight to the point of emaciation and, about 10% of the time, actual starvation). The application of this way of thinking, that is, a motivational analysis, in effect, has led to some interesting findings regarding anorexic patients. Anorexia is often thought of as a "diet gone haywire" (although it is recognized that the disorder is decidedly more complex than that). At any rate, we gave the commitment scales to a sample of anorexic patients, expecting to find significant elevations in commitment to dieting. This time our prediction was right (a pleasant

change) but only up to a point. Anorexics were reliably more committed to dieting than were normal college students, but that was not the area in which they were most deviant. Their commitment ot eating was significantly lower than normal, and by a magnitude twice the size of their elevation in dieting scores. In other words, while anorexic patients do show an elevation in motivation to diet as compared with normals, they show an even greater decline in motivation to eat. Hilde Bruch has been criticizing behavioral treatments of anorexia on the gounds that forcing these patients to eat and gain weight not only doesn't alleviate the disorder but actually seems to exacerbate it (once they escape the treatment center). Our finding that anorexics already feel extrinsically motivated to eat (i.e., forced to eat to please others) seems to support Bruch's observations, and suggests changes in treatment strategies. What appears to be needed is a focus on bolstering the intrinsic motivation to eat (for oneself, not others) with a lesser emphasis on reducing the commitment to dieting. The behavioral treatment strategy of rewarding eating (and weight gain) and punishing failure to eat (and weight loss) ignores the motivational issue. These patients already see eating as an activity they are forced to do by others. Furthermore, the motivation behind the self starvation needs more exploration--lack of commitment to eating and increased commitment to dieting may be only minor motivational issues in the development of this disorder. A more over-riding desire to control both oneself and the environment which gets expressed through eating (or not-eating) has frequently been offered as an explanation for the behavior of anorexics. These and other motivational issues connected to the development of the disorder, its maintenance, and the way therapy is viewed need to be delineated.

The dual issues of the motivations underlying a disorder and the motivations connected with seeking treatment are clearly relevant to most types of problems treated with psychotherapy. It is probably most frequently the case that

problems broght to therapy are intrinsically motivated. However, the degree of extrinsic motivation (secondary gain, or the extent to which problem behaviors are encouraged, supported, or even required by family members and significant others in the patient's life) should be assessable. There are, of course, problem behaviors which cannot be dichotomzed into intrinsic versus extrinsically motivated. For example smoking (or other addictive behaviors) is difficult to classify as intrinsic or extrinsic, since the "hooked" smoker usually reports smoking because he "has" to (i.e., he feels forced to) yet he is not doing it for anyone else or for any extrinsic reward. Obsessive-compulsive behavior is another example of a problem not easily classified on a motivational level. Analysis of the motivations underlying problem behaviors is a useful strategy regardless of whether the motivations underlying problem behaviors is a useful strategy regardless of whether the motivation is dichotomizable, and in fact, therapists are already aware of its usefulness. Motivation for neurotic or dysfunctional behavior has been attended to since Freud's days.

Something that has not received much attention, on the other hand, is a patient's motivation for therapy. Patients enter therapy for a wide variety of reasons, some intrinsically motivated, some extrinsically motivated. Yet this commitment to therapy is rarely, if ever, assessed. We therefore know little about the relation of motivation for being in therapy to outcome of therapy (specifically degree of therapeutic change or effectiveness). There are indications, however, that intrinsic motivation is considered to be desirable and perhaps useful for the success of the therapeutic process. Many clinics and private therapists demand evidence of the patient's commitment to therapy by insisting that the patient himself set up the initial appointment. Furthermore, an integral part of therapy is often the payment, and again even most clinics require some token payment from all, including the poorest patients. Why would

an intrinsic motivation for therapy be expected to be associated with a positive outcome in therapy? Let us examine a few possible extrinsic motivations and their effect on the course of therapy. Patients can be motivated extrinsically by another person (or society). For example, a spouse may suggest or demand that the other spouse get therapy for a particular problem. The reinforcement for the patient thus comes from the spouse, not the therapy. This results in a low commitment to therapy, especially if the relationship with the spouse changes.

Another extrinsic motivation for therapy is the expected outcome. For example, a patient can come for therapy to lose weight, stop smoking, or improve his interpersonal relationships. The reinforcement here comes from the outcome rather than the therapy, again resulting in a low commitment to the therapy itself. Thus when the initial novelty (and placebo effect) wear off, and it becomes clear that changes in target behaviors are slow and/or uncomfortable, the patient's remaining motivation for therapy will often not be sufficient to keep him there. It thus becomes important to know the basis of the patient's desire for therapy and its expected outcome--in other words, what is the motivation for the <u>goal</u> of therapy, intrinsic or extrinsic.

What advantages might intrinsically motivated patients have which would keep them in therapy and perhaps enhance their chances of success? A patient intrinsically motivated to seek therapy is by definition coming because he wants to, because he expects to like therapy, or because he expects therapy will feel good. Self actualizers who want to explore themselves and patients motivated by the process of therapy should tend to be highly committed to therapy since the reinforcement for the patient comes directly from the therapy, from talking about himself, gaining insights, and relaxing emotionally to another person.

If commitment to therapy influences outcome in a positive way, it would seem useful to build a patient's commitment to the therapeutic process. Since

the majority of patients are probably motivated by expected outcomes, the most common perhaps being relief of "psychic pain", we need to keep them coming long enough to at least begin to achieve some of their goals, which should be reinforcing and thus motivating. Of course, one must be prepared to deal with the patient whose motivation is exclusively intrinsic, and who may never have a decent reason for terminating therapy. In this case, however, the issues of how such a motive developed and whether and how it might be changed provide a practical challenge for the therapist. In short, while motivation has long been regarded as essential for behavior, it is past time we started examining its role in behavior change.